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	495409	A. BUILDING _____ B. WING _____	C 07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/26/16 through 07/28/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 115 at the time of the survey. The survey sample consisted of 27 Resident reviews with 23 current reviews (Residents #1 through #20 and 25,26,27) and 4 closed record reviews (Residents #21 through #24).	F 000	The submission of the Plan of Correction does not constitute agreement on the part of Abingdon Health & Rehab Center that the deficiencies cited within the report represent deficient practices on the part of Abingdon Health & Rehab Center. This plan represents our on-going pledge to provide quality care that is rendered in accordance with all regulatory requirements.	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272	272 1. Comprehensive Assessments for resident number 10, 3, 6 and 15 section V did not include date and location documentation used for CAA Summary is dually noted. 2. All resident have the potential to be affected if section V is not documented with the date and location for the CAA triggers. A review of current residents' last comprehensive assessment will be completed to ensure accurate completion of CAA's. 3. Regional MDS Consultant will educate staff responsible for the completion of section V on including date and location of information used for the CAA.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephen Reynolds — TITLE: Administrator — (X6) DATE: August 18, 2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	4. MDS Coordinator or designee will audit 10% of comprehensive assessments weekly x 1month and 10% audit of completed assessments monthly x 2 months. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. Correction date September 12, 2016	

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure accurate comprehensive MDS (minimum data set) assessments for 4 of 27 Residents, Residents #10, #3, #6, and #15.

The findings included.

1. For Resident #10, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/11/16.

Resident #10 was admitted to the facility 01/01/15. Diagnoses included, but were not limited to, dementia, anemia, hypertension, enlarged prostate, restless leg syndrome, and

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F 272	Continued From page 2 anxiety. Section C (cognitive patterns) of the Residents significant change in status MDS assessment with an ARD of 01/11/16 had a summary score of 5 out of a possible 15 points. The directions under section V of this assessment read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..." Under the column labeled "Location and Date of CAA documentation" the facility staff had documented "CAA WS (worksheet)" for the triggered areas of visual function, communication, ADL functional/rehab potential, urinary incontinence/indwelling catheter, falls, nutritional status, pressure ulcer, psychotropic drug use, and pain and had documented the date of 01/21/16. The actual location(s) regarding the documentation had not been documented. On 07/28/16 the regional MDS nurse was asked about the missing documentation. The regional MDS nurse verbalized to the surveyor that she had checked the CAA worksheets and was unable to find the supporting documentation. The administrative team was made aware of the missing MDS information during meetings with the survey team on 07/27/16 and on 07/28/16. No additional information regarding this issue was provided to the survey team prior to the exit conference. 2. The facility staff failed to document location	F 272	Refer to page 1	

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and date of the information used to complete Section V of the CAA (Care Area Assessment) for the annual MDS (minimum data set) assessment with an assessment reference date (ARD) of 11/17/15 for Resident #3.
The clinical record of Resident #3 was reviewed 7/26/16 and 7/27/16. Resident #3 was admitted to the facility on 12/7/12 and readmitted on 7/14/16 with diagnoses that included but not limited to unspecified intellectual disabilities, pneumonitis, status epilepticus, dysphagia, bipolar disorder, osteoporosis (age related), hypokalemia, sleep apnea, restless legs syndrome, anxiety, osteoarthritis, and gastroesophageal reflux disease.
Resident #3's annual MDS with an assessment reference date (ARD) of 11/17/15 coded the resident with a cognitive summary score of 13 out of 15 in Section C0500.

A review of the annual MDS referenced above revealed Resident #3 triggered for the following areas in Section V: ADL Functional/Rehabilitation, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, and Pain. For the triggered areas there was no documented location and date under the Location and Date column for these triggered areas. A review of the CAA worksheets failed to reveal a location and date for information in the clinical record.

The surveyor informed the MDS staff of the above finding on 7/26/16 at 3:40 p.m. The surveyor informed registered nurse #4 on 7/27/16 at 10:00 a.m. of the above concern regarding no date/location documented in Section V CAA and no evidence on the CAA worksheets to support the triggered items in Section V. R.N. #4 stated

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the surveyor was correct. There was no documentation of date or location on the CAA worksheets or in Section V that contained information for the triggers.

The surveyor informed the administrative staff of the above concern on 7/27/16 at 3:50 p.m.

No further information was provided prior to the exit conference on 7/28/16.

3. The facility staff failed to document location and date of the information used to complete Section V of the CAA (Care Area Assessment) for the admission MDS (minimum data set) assessment with an assessment reference date (ARD) of 11/17/15 for Resident #6.

Resident #6 was admitted to the facility 11/16/15 and readmitted 2/13/16 with diagnoses that included but not limited to diastolic heart failure, schizophrenia, chronic obstructive pulmonary disease, acute kidney failure, Type 1 diabetes mellitus, hypertensive chronic kidney disease Stage 1 through Stage 4, hyperlipidemia, urinary retention, and urinary tract infection.

Resident #6's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/23/15 assessed the resident with a brief interview for mental status (BIMS) as 14 out of 15.

A review of the admission MDS referenced above revealed Resident #6 triggered for the following areas in Section V: ADL Functional/Rehabilitation, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer, Psychotropic Drug

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F 272	Continued From page 5 Use, and Return to Community Referral. For the triggered areas there was no documented location and date under the Location and Date column for these triggered areas. A review of the CAA worksheets failed to reveal a location and date for information in the clinical record. The surveyor informed the MDS staff of the above finding on 7/26/16 at 3:40 p.m. The surveyor informed registered nurse #4 on 7/27/16 at 10:00 a.m. of the above concern regarding no date/location documented in Section V CAA and no evidence on the CAA worksheets to support the triggered items in Section V. R.N. #4 stated the surveyor was correct. There was no documentation of date or location on the CAA worksheets or in Section V that contained information for the triggers. The surveyor informed the administrative staff of the above concern on 7/27/16 at 3:50 p.m. No further information was provided prior to the exit conference on 7/28/16. 4. The facility staff failed to document location and date of the information used to complete Section V of the CAA (Care Area Assessment) for the significant change in assessment MDS (minimum data set) assessment with an assessment reference date (ARD) of 12/22/15 for Resident #15. The surveyor reviewed Resident #15's clinical record on 7/27/16 and 7/28/16. Resident #15 was admitted to the facility 2/18/13 and readmitted 12/15/15 with diagnoses that included but not limited to end stage renal disease, dependence on renal dialysis, schizoaffective	F 272	Refer to Page 1	

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F 272	Continued From page 6 disorder, bipolar type, major depressive disorder, hypertensive chronic kidney disease stage 5, dysphagia, hypothyroidism, gastroesophageal reflux disease, and unspecified psychosis. Resident #15's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/22/15 assessed the resident with a brief interview for mental status (BIMS) as 11 out of 15. A review of the significant change in assessment MDS referenced above revealed Resident #15 triggered for the following areas in Section V: Delirium, Cognitive Loss/Dementia, ADL Functional/Rehabilitation, Urinary Incontinence and Indwelling Catheter, Mood State, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. The decision was made not to care plan delirium. Section V CAA summary date/location was present for the triggered areas of cognition, and mood; however, the triggered areas of ADL, Urinary incontinence, Falls, Nutrition, Pressure Ulcer and Psychotropic Drug Use with the decision made to care plan these triggered areas did not reveal the date or location where evidence in the clinical record could be found to support the triggered areas. A review of the CAA worksheets failed to reveal a location and date for information in the clinical record. The surveyor informed the MDS staff of the above finding on 7/28/16 9:30 a.m. R.N. #4 stated the surveyor was correct. There was no documentation of date or location on the CAA worksheets or in Section V that contained information for the triggers.	F 272	Refer to Page 1	

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F 272	Continued From page 7 The surveyor informed the administrative staff of the above concern on 7/28/16 at 10:40 a.m. No further information was provided prior to the exit conference on 7/28/16.	F 272		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278	278 1. Resident #12 ARD 6/23/16 modified to reflect bathing. Resident #13 ARD 7/15/16 modified to reflect PASSR coding. Resident #17 ARD 4/28/16 modified to reflect bathing and PASSR. Resident #4 ARD 6/30/16 modified to reflect height and bathing. Resident #10 ARD 6/14/16 modified to reflect height. Resident #19 ARD 6/29/16 modified to reflect bathing. Resident #1 ARD 7/17/16 modified to reflect bathing. Resident #20 ARD 7/21/16 was modified to reflect bathing. 2. All resident have the potential to be affected by inaccurate coding of PASSR, Height, and Bathing. These are sections A, K, and G. Assessments for past 30 days will be audited in these sections for accuracy. 3. MDS Regional Consultant will educat MDS staff responsible for completion of sections A, K, and G.	

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by:
Based on staff interview and clinical record, the facility staff failed to ensure an accurate and complete Minimum Data Set (MDS) for 8 of 27 residents in the survey sample (Residents ' #12, 13, 17, 4, 10, 19, 20 and 1).

The findings included:
1. The facility staff failed to correctly code bathing on the MDS (Minimum Data Set) for Resident #12.
Resident #12 was readmitted to the facility on 3/16/16 with the following diagnoses of, but not limited to irregular heartbeat, high blood pressure, end-stage kidney disease, diabetes, depression, dysphagia, sleep apnea and gastrostomy. The resident was coded on the MDS with an ARD (Assessment Protocol Date) of 6/23/16 had a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #12 was also coded as requiring extensive assistance with 1 staff member for dressing and personal hygiene.

The surveyor conducted a review Resident #12 ' s clinical record on 7/27/16. The surveyor noted that on the MDS with an ARD date of 6/23/16, under Section G 0120 Bathing, the resident was coded for Self-Performance as an " 8 " and Support Provided as an " 8 " also. In this area, the code of " 8 " for Self-Performance stood for " Activity itself did not occur or family and/or non-facility staff provided 100% of the time for that activity over the entire 7-day period. " For Support Provided, the " 8 " code stood for " ADL (Activities of Daily Living) activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period. "

4. MDS Coordinator or designee will audit 10% of assessments weekly x 1 month and monthly x 2 months to ensure accurate coding of sections A, K, and G. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance Committee for review and further analysis and findings.
5. Correction date September 12, 2016

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MDS Corporate Nurse was notified of the above documented findings on 7/27/16 at approximately 8:45 am. The MDS corporate Nurse stated, " Let me pull up some papers and I will bring it to you. That may be inaccurate. "

At 10:30 on 7/27/16, the MDS Corporate Nurse returned to the surveyor and stated, " The nurse that pulled this for the MDS ...did not refresh the page to obtain the updated information for this area on the MDS. "

On 7/27/16 at 3:14, the administrator, director of nursing, assistant director of nursing were notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 7/28/16.

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2. The facility staff failed to correctly code the Preadmission Screening and Resident Review (PASRR) on the MDS (Minimum Data Set) for Resident #13.
Resident #13 was readmitted to the facility on 3/30/16 with the following diagnoses of, but not limited to blood clot, thyroid disorder, dementia, Parkinson ' s Disease, seizures, respiratory failure, intracranial hemorrhage, tracheostomy, gastrostomy and chronic pain. The resident was coded, on the MDS (an assessment protocol) with an ARD (Assessment Reference Date) of 7/15/16 as having short and long term memory loss. Resident #13 was also coded as being severely impaired to make daily decisions. The resident requires extensive assistance with 2 or more staff members for dressing and personal hygiene and was totally dependent on staff for

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bathing.

The clinical record of Resident #13 was reviewed by the surveyor on 7/27/2016. It was noted by the surveyor on the MDS with an ARD of 7/15/16, under Section A with questions numbered 1500 and 1510, the PSARR screening was incorrectly coded with dashes in the boxes.

The MDS Corporate Nurse was notified of the above documented findings on 7/27/16 at 5:20 pm by the surveyor. The MDS Corporate Nurse stated, " Those shouldn ' t be in there. I educated the one that did that yesterday. "

On 7/28/16 at 3:15 pm, the administrator, director of nursing, assistant director of nursing, MDS corporate nurse, corporate wound care specialist and clinical services specialists were notified of the above documented findings.

There was no further information provided to the surveyor prior to the exit conference on 7/28/16.

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3. The facility staff failed to correctly code the Preadmission Screening and Resident Review (PASRR) and bathing on the MDS (Minimum Data Set) for Resident #17.
Resident #17 was admitted to the facility on 4/20/16 with the following diagnoses of, but not limited to end stage renal disease, dialysis, diabetes, thyroid disorder and bacterial pneumonia. The resident was coded, on the MDS (an assessment protocol) with an ARD (Assessment Reference Date) of 4/27/16 as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #17 required limited assistance of 1staff

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member for dressing and personal hygiene.

The clinical record of Resident #17 was reviewed by the surveyor on 7/28/2016. It was noted by the surveyor on the MDS with an ARD of 4/27/16, under Section A, question # ' s 1500 and 1510; the PSARR screening was incorrectly coded with dashes in the boxes. Section G, question #0120 was incorrectly coded with " 8 " for Self Performance and Support provided for bathing of the resident. In this area, the code of " 8 " for Self-Performance stood for " Activity itself did not occur or family and/or non-facility staff provided 100% of the time for that activity over the entire 7-day period. " For Support Provided, the " 8 " code stood for " ADL (Activities of Daily Living) activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period. "

The MDS Corporate nurse was notified of the above documented findings on 7/28/16 at 1:30 pm by the surveyor. The MDS Corporate Nurse stated, " It is wrong. "

On 7/28/16 at 3:15 pm, the administrator, director of nursing, assistant director of nursing, MDS corporate nurse, corporate wound care specialist and clinical services specialists were notified of the above documented findings.

There was no further information provided to the surveyor prior to the exit conference on 7/28/16.

4. The facility staff failed to ensure Resident #4's significant change in assessment minimum data set (MDS) assessment with an ARD date of 6/30/16 was accurate. Section G Bathing had dash marks recorded for self-performance and

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support provided. Section K had a dash mark for Resident #4's height.

The clinical record of Resident #4 was reviewed 7/26/16 and 7/27/16. Resident #4 was admitted to the facility 10/3/13 with diagnoses that included but not limited to Alzheimer's disease, anxiety, dysphagia, gastroesophageal reflux disease, glaucoma, atherosclerotic heart disease, gastrostomy, peripheral vascular disease, and hereditary and idiopathic neuropathy.

Resident #4's significant change in assessment with an assessment reference date (ARD) of 6/30/16 assessed the resident with a cognitive summary score of 10 out of 15 in Section C Summary Score. Further review of the significant change MDS revealed in Section G Functional Status and more specifically in G0120 Bathing that there were "dash marks" for A. Self-Performance and B. Support Provided. Section K had a dash mark for height.

The June 2016 ADL (activities of daily living) were reviewed for the 7 day look back period. There were no documented baths on the electronic record.

The surveyor interviewed minimum data set (MDS) registered nurse #2 on 7/27/16 at 9:30 a.m. concerning the dash marks in Section G and Section K. R.N. #2 stated Resident #4 had to be handled with gloves at times when it came to giving baths. R.N. #2 stated that often she did not always have access to the paper documentation for baths. She stated the paper work sometimes was locked up in the manager's office. The surveyor requested the paper documentation for baths for the look back period

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	495409	A. BUILDING _____ B. WING _____	C 07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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in June 2016.

The surveyor questioned the dash marks for height in Section K and why the height wasn't obtained. R.N. #2 stated Resident #4 was on comfort care and obtaining the height might have been uncomfortable for her.

A review of the assignment sheet for Resident #4's unit revealed baths/showers were given 6/2/16, 6/7/16, 6/10/16, 6/14/16, 6/17/16, 6/21/16, 6/24/16, 6/25/16, and 6/29/16. The look back period was 6/24/16 through 6/30/16. Resident #4 received three showers/baths during this time.

The surveyor interviewed R.N. #4 after reviewing the bath record and stated the facility needed to work on the process for documentation.

The surveyor informed the administrative staff of the above finding on 7/27/16 at 3:50 p.m.

No further information was provided prior to the exit conference on 7/28/16.

5. For Resident #10, the facility staff failed to document the Residents height on a quarterly MDS (minimum data set) assessment.

Resident #10 was admitted to the facility 01/01/15. Diagnoses included, but were not limited to, dementia, anemia, hypertension, enlarged prostate, restless leg syndrome, and anxiety.

Section C (cognitive patterns) of the Residents quarterly MDS assessment with an ARD of 06/14/16 had a summary score of 7 out of a possible 15 points. Section K0200 (height/weight) had a dash in the boxes that should have

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included the Residents height.

On 07/28/16 at approximately 1:25 p.m. the surveyor interviewed RN (registered nurse) #2 regarding the missing height. After reviewing the MDS and the electronic clinical record RN #2 verbalized to the surveyor that the height (70") documented in the clinical record was over a year old and another height should have been obtained.

The administrative staff were notified of the missing height in a meeting with the survey team on 07/28/16 at approximately 3:15 p.m.

No further information regarding the missing height was provided to the surveyor prior to the exit conference.

6. For Resident #19, the facility staff coded the Residents bathing status 8/8 (activity did not occur) on the Residents significant change in status assessment.

Resident #19 was admitted to the facility 08/28/15. Diagnoses included, but were not limited to, dementia, chronic kidney disease, diabetes, anemia, restless leg syndrome, depressive disorder, and diabetic neuropathy.

Section C (cognitive patterns) of the Residents significant change in status assessment with an ARD (assessment reference date) of 06/29/16 had a summary score of 15 out of a possible 15 points. Indicating the Resident was alert and orientated. Section G (functional status) was coded 8/8 for bathing indicating the activity did not occur.

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During an interview with Resident #19 on 07/28/16 at approximately 10:45 a.m. Resident #19 verbalized to the surveyor that she received her 2 baths a week and would give herself a sponge bath on the days she did not get her bath.

On 07/28/16 at approximately 10:50 a.m. the surveyor interviewed LPN (licensed practical nurse) #6 regarding the coding status on the MDS assessment. LPN #6 reviewed the MDS and stated I think they are documenting the baths on the shower sheets but not marking it in the system. LPN #6 then added they did not have access to the shower sheets.

The administrative staff were notified of the incorrect documentation on the MDS regarding bathing during a meeting with the survey team on 07/28/16 at approximately 3:15 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

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7. For Resident #1, the facility staff failed to ensure the MDS assessment was accurate and complete.

Resident #1 was admitted to the facility on 07/24/16. Diagnoses included but not limited to hypertension, anxiety, anemia, stroke, liver disease, schizoaffective bipolar type, and arthritis.

The most recent MDS with an ARD (assessment reference date) of 7/17/16, resident #1 was coded an 8 under self-performance and 8 under support provided. An 8 is the code for ADL (activities of daily living). The coding indicated that the ADL activity did not occur or family and/ or non- facility

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staff provided the care 100% of the time for that activity over a 7 day period. Under support the 8 is coded to indicate that no support was provided.

Resident #1 ' s bathing record indicted bathing had occurred during the 7 day look back period.

The surveyor spoke with the MDS coordinator on 7/27/16 at approximately 11:00 am, regarding the coding on the MDS. The MDS coordinator stated, "LPN (licensed practical nurse) #6 regarding the coding status on the MDS assessment. LPN #6 reviewed the MDS and stated I think they are documenting the baths on the shower sheets but not marking it in the system. RN #8 was present for the conversion and said " we didn ' t have an assessment. "

The incorrect coding for Resident #1's MDS assessment was discussed for a final time with the facility's administrator and director of nursing, during a survey team meeting, on the afternoon of 7/28/16. No further information was provided to the surveyor related to the inaccurate MDS.

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8. For Resident #20, the facility staff failed to ensure the MDS assessment was accurate and complete.

Resident #20 was admitted to the facility on 07/14/16. Diagnoses included but not limited to hypertension, anxiety, stroke, diabetes, renal disease, and arthritis.

The most recent MDS with an ARD (assessment reference date) of 7/21/16, for Resident #20, was coded an 8 under self-performance and 8 under support provided. An 8 is the code for ADL

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F 278	Continued From page 17 (activities of daily living), indicating that the ADL activity did not occur or family and/ or non- facility staff provided the care 100% of the time for that activity over a 7 day period. For the 8 under support provided indicated that no support was provided. Resident #20 ' s bathing record revealed bathing had occurred during the 7 day look back period. The surveyor spoke with the MDS coordinator on 7/27/16 at approximately 11:00 am, regarding the coding on the MDS. The MDS coordinator LPN (licensed practical nurse) #6 reviewed the MDS and stated, " I think they are documenting the baths on the shower sheets but not marking it in the system. " RN (Registered Nurse) #8 was present for the conversion and said " we didn ' t have an assessment. " The incorrect coding for Resident #20's MDS assessment was discussed for a final time with the facility's administrator and director of nursing, during a survey team meeting, on the afternoon of 7/28/16. No further information was provided to the surveyor related to the inaccurate MDS.	F 278	Refer to Page 8	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	279 1. Resident #5 care plan updated to reflect dental. 2. All residents are at risk for incomplete comprehensive care plan development. Comprehensive Assessments and care plans completed in the past 30 days will be audited for accuracy.	

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The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to develop a CCP (comprehensive care plan) for 1 of 27 Residents, Resident #5.

The Findings Included:

For Resident #5 the facility staff failed to develop a CCP for dental.

Resident #5 was admitted to the facility 01/09/13. Diagnoses included, but were not limited to, dementia with behavior disturbances, hypertension, constipation, anxiety, and dysphagia.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/28/15 had a documented summary score of 9 out of a possible 15 points. Section L (oral/dental status) was coded to indicate the Resident had no natural teeth and was edentulous. Section V (care area assessment summary) had triggered for the area of dental care and the staff had

3. Regional MDS Consultant educated MDS staff regarding development of comprehensive care plan.
4. MDS Coordinator or designee Will audit 10% of comprehensive care plans weekly x 1 month and monthly x 2 months to ensure care areas are appropriately care planned. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance Committee for review and further analysis and findings.
5. Correction date September 12, 2016

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F 279	Continued From page 19 indicated they would develop a CCP for dental. When reviewing the CCP the surveyor was unable to locate where the staff had care planned dental. On 07/27/16 at approximately 9:10 a.m. the surveyor reviewed the MDS and CCP with RN (registered nurse) #2. After reviewing the MDS and CCP RN #2 verbalized to the surveyor that the area of dental had not been care planned. The administrative staff were notified of the missing dental care plan during meetings with the survey team on 07/27/16 at 3:45 p.m. and on 07/28/16 at 3:15 p.m. No further information regarding the missing care plan for dental was provided to the survey team prior to the exit conference.	F 279	Refer to Page 18	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280	280 1. Care plan for resident #12 updated to reflect fall noted on 7/22/16. 2. Any resident has the potential to be affected if care plan is not updated with fall occurrences and interventions necessary to reduce risk of future falls. 3. DON or designee to educate licensed nursing staff on updating care plans for falls and intervention.	

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F 280	Continued From page 20 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to revise a comprehensive care plan (CCP) for 1 of 27 residents (Resident #12). The findings included: Resident #12 was readmitted to the facility on 3/16/16 with the following diagnoses of, but not limited to irregular heartbeat, high blood pressure, end-stage kidney disease, diabetes, depression, dysphagia, sleep apnea and gastrostomy. The resident was coded on the MDS with an ARD (Assessment Protocol Date) of 6/23/16 had a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #12 was also coded as requiring extensive assistance with 1 staff member for dressing and personal hygiene. The clinical record of Resident #12 was reviewed by the surveyor on 7/27/16. The surveyor noted a nursing note dated and timed for 7/22/16 at 1315 (1:15 pm) which stated, " Summoned to the resident room by CNA (Certified Nurse ' s Assistant) reporting resident on the floor upon entering resident room noted resident laying on gray mat on floor beside bed on her left side resident stated was getting up and fell resident assessed for injury no noted injury ... "	F 280	4. NSG Manager or designee to audit 10% of care plans weekly x 1 month then10% monthly x 2 months to ensure care plans are reflective of fall updates with intervention. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. Correction date September 12, 2016	

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Resident #12 ' s comprehensive care plan (CCP) was also reviewed by the surveyor. The surveyor noted that the last revision to the resident ' s care plan for falls was dated 7/7/16 which was made by the facility ' s MDS Coordinator.

Unit Manager #1 was notified of the above documented findings on 7/27/16 at 5:40 pm by the surveyor. Unit Manager #1 stated, " I will look into this for you. The QA (Quality Assurance) nurse revises all the care plans. "

On 7/28/16 at approximately 1:30 pm, Unit Manager #1 came into the conference room and stated to the surveyor that the care plan for resident ____(name of resident) had not been updated for the fall that had occurred on 7/22/16.

On 7/28/16 at 3:15 pm, the administrator, director of nursing, assistant nursing, MDS corporate nurse, corporate wound care specialist and clinical services specialists were notified of the above documented findings.

At 3:55 pm, the director of nursing came into the conference room and stated to the surveyor that she had checked into this matter and the nurse " did not update the care plan " to include the resident ' s fall.

No further information was provided to the surveyor prior to the exit conference on 7/28/16.

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F 309 SS=E 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING — F 309

Each resident must receive and the facility must provide the necessary care and services to attain

Please see next page

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or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review facility staff failed to provide services for the highest practicable well-being for 4 of 27 Residents, Residents #5, #10, #12, and #15.

The findings included.

1. For Resident #5, the facility staff failed to administer the physician ordered medication buspar as ordered.

Resident #5 was admitted to the facility 01/09/13. Diagnoses included, but were not limited to, dementia with behavior disturbances, hypertension, constipation, anxiety, and dysphagia.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/01/16 had a documented summary score of 8 out of a possible 15 points.

The Residents electronic clinical record included a physicians order dated 05/14/16 for buspar 7.5 mg give 1 tablet by mouth two times a day for anxiety.

A review of the Residents eMAR (electronic

F 309 Provide care/services for Highest Well Being

1. LPN #3 received 1:1 education regarding contents of stat box and need to contact pharmacy if unsure if tablet can be cut or broken to obtain correct dose. Physician for Resident #5 was notified that resident had not received Buspar on 5/14/16 evening shift. No negative outcome to resident.

The attending physician for resident #10 was informed of the missing documentation for administration of Pro-Stat on 7/18, 7/19 and 7/20/16. There was no negative outcome to resident #10.

The attending physician for resident #12 was notified that the 7/8/16 order for "evaluation of new wheelchair cushion" had not been completed. Physical Therapy completed the evaluation on 7/28/16 and recommended a Roho cushion to wheelchair. This was ordered for resident and place in wheelchair when received.

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medication administration record) indicated that this medication was administered by LPN (licensed practical nurse) #4 on 05/14/16 at 9:00 a.m. However, LPN #3 documented that for the evening dose she was "awaiting arrival from pharmacy."

A review of the stat box list indicated that buspirone (buspar) 5 mg tablets were available in the stat box for administration.

On 07/27/16 at approximately 2:00 p.m. the surveyor contacted the facility pharmacy and spoke with pharmacist #1. Pharmacist #1 was asked if buspar could be cut or split in half for administration. Pharmacist #1 verbalized to the surveyor that buspar tablets could be cut or broken in half.

On 07/27/16 at approximately 4:55 p.m. LPN #3 was asked about the evening dose of buspar. After reviewing the eMAR LPN #3 verbalized to the surveyor that she probably would have not have divided the 5 mg tablet of buspar in the stat box.

On 07/28/16 at approximately 8:55 a.m. the surveyor interviewed LPN #4. After reviewing the eMAR LPN #4 stated buspar was available in the stat box and she would have obtained the medication from the stat box for administration and would have broken or cut the pill in half if needed.

The administrative staff were notified of the above in a meeting with the survey team on 07/28/16 at approximately 3:15 p.m.

No further information regarding this issue was

Attending physician for Resident #12 also notified that nonpharmacological interventions were not used prior to administration of ordered Morphine on 7/15, 7/16, 7/20 and 7/22/16.

Resident #15s order for dialysis has been scanned into the system.

2. Any resident has the potential to be affected by not having medication or devices available as ordered, if nonpharmacological interventions are not offered prior to medication administration or if orders are not written for procedures.
3. Licensed nursing staff will be educated on medication administration to include the facility's policy and procedure for obtaining medication from the pharmacy in a timely manner, use of emergency stat box, facility's process for ensuring communication with therapy regarding MD orders and scanning of orders into system for all procedures.

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provided to the survey team prior to the exit conference.

2. For Resident #10, the facility staff failed to administer the nutritional supplement Pro-stat as ordered by the physician.

Resident #10 was admitted to the facility 01/01/15. Diagnoses included, but were not limited to, dementia, anemia, hypertension, enlarged prostate, restless leg syndrome, and anxiety.

Section C (cognitive patterns) of the Residents quarterly MDS assessment with an ARD of 06/14/16 had a summary score of 7 out of a possible 15 points.

The Residents clinical record included orders for Pro-Stat Liquid Give 30 cc by mouth three times a day for Prophylaxis. The order date was documented as 07/18/16.

The nursing staff had documented in the clinical record on 07/19 and 07/20/16 "...Medication unavailable, awaiting delivery."

The eMAR was marked to indicate the Pro-stat was not administered on 07/18, 07/19, and for 9:00 a.m. and 1:00 p.m. on 07/20. The nursing had documented that the Pro-stat was administered at 5:00 p.m. on 07/20/16.

Per the facility staff the Pro-stat is not provided by the pharmacy. When asked why the physician had ordered the Pro-stat for Resident #10 the unit manager provided the surveyor with a copy of a lab test indicating the Residents protein level was low at 5.5 the reference range was documented

4. The Director of Nursing and/or designee will audit new orders and or admissions/re-admissions orders and the 24 hour clinical report to ensure medication availability and to ensure non-pharmacological interventions are documented prior to administering pain medications daily (M-F) x4 weeks, then weekly x8 weeks. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.
5. Correction date September 12, 2016

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as 6.4-8.3.

The administrative staff were notified of the unavailability of the nutritional supplement Pro-stat during a meeting with the survey team on 07/28/16 at approximately 3:15 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3a. The facility staff failed to notify the physical therapy department of an evaluation ordered by the physician Resident #12.

Resident #12 was readmitted to the facility on 3/16/16 with the following diagnoses of, but not limited to irregular heartbeat, high blood pressure, end-stage kidney disease, diabetes, depression, dysphagia, sleep apnea and gastrostomy. The resident was coded on the MDS with an ARD (Assessment Protocol Date) of 6/23/16 had a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #12 was also coded as requiring extensive assistance with 1 staff member for dressing and personal hygiene.

The clinical record of Resident #12 was reviewed by the surveyor on 7/27/16. It was noted by the surveyor that on 7/8/16 the physician had given an order that stated the following, " PT (physical therapy) to eval (evaluation) for new WC (wheelchair) cushion. " The surveyor could not locate the documentation of the PT evaluation in the clinical record of Resident #12.

Unit Manager #1 was notified of the above documented findings. The surveyor requested to interview the physical therapy director on 7/28/16.

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Unit Manager #1 stated that this information would be passed on to the appropriate person in that department.

The surveyor notified the administrator, director of nursing, assistant director, would care specialist and clinical services specialist of the above documented findings on 7/27/16 at 3:45 pm.

On 7/28/16 at 1:45 pm, the physical therapy director came into the conference room to speak to the surveyor concerning Resident #12. The surveyor notified the physical therapy director of the above documented findings. The physical therapy (PT) director stated, " I just the order this morning to evaluate the resident for this. We have ordered her a Roho cushion and it will be here in 2 days. " The surveyor requested a copy of the evaluation that had been done on Resident #12 this morning. The surveyor asked the PT director what the process was in getting an order that the nurses had received for a PT evaluation. The PT director stated, " The nurses would copy the order and bring it to PT. I don ' t know what happened this time. "

There was no further information provided to the surveyor prior to the exit conference on 7/28/16.

3b. The facility staff failed to use non-pharmacological interventions prior to the administration of a pain medication for Resident #12.

Resident #12 was readmitted to the facility on 3/16/16 with the following diagnoses of, but not limited to irregular heartbeat, high blood pressure, end-stage kidney disease, diabetes, depression, dysphagia, sleep apnea and gastrostomy. The

Please refer to page 23.

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resident was coded on the MDS with an ARD (Assessment Protocol Date) of 6/23/16 had a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #12 was also coded as requiring extensive assistance with 1 staff member for dressing and personal hygiene.

The clinical record of Resident #12 was reviewed by the surveyor on 7/27/16. The physician had ordered " Morphine Sulfate (Concentrate) Solution 20 mg/ml (milligram/milliliter) Give 0.25 ml sublingually (under the tongue) every 4 hours as needed for pain/air hunger. " The surveyor noted that Morphine, which is a pain medication, was administrated to Resident #12 on the following dates and times: 7/22/16 at 9:13 pm, 7/20/16 at 10:15 pm, 7/16/16 at 3:14 pm and 7/15/16 at 5:17 pm. There was no documentation noted that non-pharmacological interventions were used prior to the administration of this pain medication for these dates and times.

Unit Manager #1 was notified by the surveyor on 7/27/16 at 5:45 pm of the above documented findings. Unit Manager #1 stated to the surveyor that she would have to look into this and get back with the surveyor concerning this matter.

On 7/28/16 at 1 pm, the Unit Manager stated, " We looked at the chart and you are right. There were no interventions used before the staff gave the resident the Morphine. "

The administrator, director of nursing, assistant director of nursing and clinical services specialist were notified of the above documented findings on 7/28/16 at 3:15 pm.

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No further information was provided to the surveyor prior to the exit conference on 7/28/16.
4. The facility staff failed to ensure the necessary care and treatment was provided to a dialysis resident and failed to ensure coordination of care with the dialysis center was provided for Resident #15.

The surveyor reviewed Resident #15's clinical record on 7/27/16 and 7/28/16. Resident #15 was admitted to the facility 2/18/13 and readmitted 12/15/15 with diagnoses that included but not limited to end stage renal disease, dependence on renal dialysis, schizoaffective disorder, bipolar type, major depressive disorder, hypertensive chronic kidney disease stage 5, dysphagia, hypothyroidism, gastroesophageal reflux disease, and unspecified psychosis.

Resident #15's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/22/15 assessed the resident with a brief interview for mental status (BIMS) as 11 out of 15.

Resident #15's current comprehensive care plan dated initiated 6/10/15 for dialysis was reviewed. Interventions/Tasks read in part "Assess bruit and thrill as ordered and coordinate care with dialysis center as indicated."

Resident #15 had physician's orders for dialysis on Monday, Wednesday, and Friday at _____ (name of a local dialysis facility.) The order was signed and dated by the physician on 7/11/16.

The surveyor reviewed the electronic clinical record and was unable to locate any scanned documents for dialysis.

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The surveyor interviewed licensed practical nurse #2 on 7/28/16 at 8:35 a.m. L.P.N. #2 was asked if the facility had communication sheets between the dialysis center and the facility. L.P.N. #2 provided the surveyor with a dialysis notebook for Resident #15. L.P.N. #2 obtained the dialysis notebook from Resident #15's dialysis duffel bag.

The July 2016 Dialysis Communication Sheet was reviewed. Entries on the form included: date, weight (pre) weight (post), labs, changes in condition, changes in medications, diet to center, nutrition % taken, and signature. Of the eight entries on the dialysis form, none were completed entirely. L.P.N. #2 stated the facility doesn't send a communication sheet to the dialysis center each time Resident #15 went to dialysis. "We are to fill this out" and handed the surveyor the Dialysis Communication Form.

There were no dialysis communication sheets used to share the flow of information between the facility and the dialysis center.

The surveyor interviewed R.N. #1 on 7/28/16 at 9:25 a.m. R.N. #1 stated the facility doesn't send a communication form with each dialysis day but communicates via phone if there are any changes, pertinent labs. R.N. #1 provided laboratory results obtained at the dialysis center for Resident #15. R.N. #1 stated the dialysis center would call with concerns.

The surveyor requested the facility contract for dialysis from the administrator on 7/28/16.

The contract titled "SNF Outpatient Dialysis Services Agreement" read in part "A. Obligations

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F 309	Continued From page 30 of Nursing Facility and/or Owner 2. Interchange of Information. The Nursing Facility shall provide for the interchange of information useful or necessary for the care of the ESRD (end stage renal disease) Residents, including a Registered Nurse as a contact person at the Nursing Facility whose responsibilities include oversight of provision of Services to the ESRD Residents. B. Obligations of the ESRD Dialysis Unit and/or Company D. To provide to the Nursing Facility information on all aspects of the management of the ESRD Resident's care related to the provision of Services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding, infection, and care of dialysis site." The surveyor informed the administrator, the director of nursing, and the assistant director of nursing of the lack of coordination of dialysis care for Resident #15 with the contracting dialysis center on 7/28/16 at 10:40 a.m. No further information was provided prior to the exit conference on 7/28/16.	F 309	Please refer to page 23.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		

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Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to follow physician ordered parameters prior to administering a hypertensive medication for 1 of 27 Residents, Resident #10.

The findings included.

The facility staff failed to follow the physician ordered parameters regarding a blood pressure medication.

Resident #10 was admitted to the facility 01/01/15. Diagnoses included, but were not limited to, dementia, anemia, hypertension, enlarged prostate, restless leg syndrome, and anxiety.

Section C (cognitive patterns) of the Residents quarterly MDS assessment with an ARD of 06/14/16 had a summary score of 7 out of a

F 329 Drug Regimen is Free from Unnecessary Drugs

1. The parameters needed for resident #10s administration of metoprolol have been placed on the medication administration record (MAR).
2. Any resident with medications that require parameters has the potential to be affected. Residents with parameters for medication administration will have their records audited to ensure that required parameters for administration are on the MAR with the medication.
3. DON will complete education for licensed staff on having parameters on the MAR.
4. The D.O.N or designee will conduct audits on physician orders with parameters X3 months to ensure parameters are located on MARS that require the parameters. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.
5. Correction date September 12,

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possible 15 points. Section I (active diagnoses) included the active diagnosis of hypertension.

The Residents clinical record included physician orders for "Metoprolol Tartrate Tablet 25 MG Give 1 tablet by mouth at bedtime for Hypertension Hold for Systolic BP (blood pressure) < (less than) 100 or diastolic BP <60 or Heart Rate <60. Notify MD (medical doctor) if held three times or more." The order date was documented as 03/29/16.

A review of the Residents eMARs (electronic medication administration records) indicated that this medication had been administered every night at 2100 (9:00 p.m.) for the month of July. However, the surveyor was unable to locate documentation to indicate the parameters set by the physician had been followed.

On 07/26/16 at approximately 2:40 p.m. the surveyor and the unit manager reviewed the Residents clinical record. The unit manager was only able to provide the surveyor with BPs that had been obtained on-
07/04 at 11:02 a.m.
07/05 at 10:29 a.m.
07/06 at 9:45 a.m.
07/07 at 14:50 (2:50 p.m.)
07/09 at 10:31 a.m.
07/10 at 10:56 a.m.
07/12 at 22:16 (10:16 p.m.)
07/14 at 14:13 (2:13 p.m.)
07/15 at 1:25 a.m.
07/18 at 14:59 (2:59 p.m.)

No heart rates were provided.

The administrative staff were notified of the

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F 329	Continued From page 33 missing physician ordered parameters during a meeting with the survey team on 07/28/16 at approximately 3:15 p.m. No further vital signs were provided to the surveyor prior to the exit conference.	F 329	Please refer to page 32	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure a medication error rate less than 5 %. There were 2 medication errors out of 27 opportunities for a medication error rate of 7.4% that affected 2 of 27 residents (Resident #15 and Resident #26). The finding included: 1. The facility staff failed to administer Resident #15's eye drops by the manufacturer ' s package insert. The facility staff failed to wait 3 minutes between each eye drop administered into Resident #15's eyes. The surveyor observed a medication pass and pour on 7/26/16 at 4:40 p.m. with licensed practical nurse #1. L.P.N. #1 prepared two medications for Resident #15-Renvela and Artificial Tears Solution 1.4 % (PolyvinylAlcohol). L.P.N. #1 placed the Renvela in a medication cup and administered the medication with applesauce. L.P.N. #1 then donned gloves and	F 332	**F 332 Medication Error Rate** 1. A medication error report has been completed for the administration of resident #15's eye drops. The physician was notified of error. A medication error report has been completed for Resident #26's Cymbalta that was crushed. The physician was notified of error. 2. Any resident who receives medications has the potential to be affected by a medication error. 3. Licensed nursing staff will be educated on the proper method of administering medications to include eye drops and medications that cannot be crushed.	

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placed one drop of the Artificial Tears in the left eye followed by a second drop in the left eye.
The same eye medication administration procedure was observed with the right eye.
L.P.N. #1 offered Resident #15 a tissue.
Resident #15 dabbed the corner of both eyes briefly.
L.P.N. #1 failed to wait 3-5 minutes between each eye drop administration of the Artificial Tears.
The surveyor reconciled the medications administered with the signed physician order dated 7/11/16. The physician order read "Artificial Tears Solution 1.4% (Polyvinyl Alcohol) Instill 2 drops in both eyes four times a day related to DRY EYE SYNDROME OF UNSPECIFIED LACRIMAL GLAND (H04.129)."
The surveyor requested the manufacturer's package insert/specifications from registered nurse #4 on 7/27/16 at 8:00 a.m.
The surveyor was provided the facility policy titled "Policy 5.3.1 Ophthalmic Drop Administration Effective Date: 8/1/2009, Revised Date: 8/7/2012, Review Date: 8/1/2010, 10/1/2011, State(s) Applicable: All regions" by the corporate registered nurse #2 on 7/27/16 at 11:00 a.m. The surveyor had requested the manufacturer's package insert/product specifications from R.N. #1 not the facility policy. The surveyor did not receive the package insert with specifications for admininstration of Artifical Tears from the facility
The policy read "Procedure Note: If more than one drop of the same medication is required for the same eye OR if an additional eye drop medication is required for administration, wait 3-5 minutes between drops to allow adequate contact time for each eye drop."
The following information was obtained from the State Operations Manual and read under medication administration: "Eye Contact: The

4. DON and/or designee will conduct (3) medication pass observations weekly X 4 weeks and then 1 weekly X 8 weeks to monitor for correct medication administration.. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.
5. Correction date September 12, 2016

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eye drop, but not the dropper, must make full contact with the conjunctival sac and then be washed over the eye when the resident closes the eyelid; and Sufficient Contact Time: The eye drop must contact the eye for a sufficient period of time before the next eye drop is instilled. The time for optimal eye drop absorption is approximately 3 to 5 minutes. (It should be encouraged that when the procedures are possible, systemic effects of eye medications can be reduced by pressing the tear duct for one minute after eye drop administration or by gentle eye closing for approximately three minutes after the administration.)"

The surveyor discussed the medication pass observation with L.P.N. #1 on 7/27/16 at 3:40 p.m. L.P.N. #1 stated she didn't know that there was a 3-5 wait time between drops for artifical tears. She stated she thought that was just for medicated eye drops.

The surveyor informed the administrative staff of the above finding on 7/27/16 at 3:50 p.m. and requested the facility policy on medication administration.

No further information was provided prior to the exit conference on 7/28/16.

The surveyor reviewed Resident #15's clinical record on 7/27/16 and 7/28/16. Resident #15 was admitted to the facility 2/18/13 and readmitted 12/15/15 with diagnoses that included but not limited to end stage renal disease, dependence on renal dialysis, schizoaffective disorder, bipolar type, major depressive disorder, hypertensive chronic kidney disease stage 5, dysphagia, hypothyroidism, gastroesophageal

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reflux disease, and unspecified psychosis. Resident #15's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/22/15 assessed the resident with a brief interview for mental status (BIMS) as 11 out of 15.

2. L.P.N. #2 crushed Resident #26's Cymbalta during a medication pass and pour on 7/27/16.

The surveyor observed a medication pass and pour on 7/27/16 at 8:00 a.m. with licensed practical nurse #2. L.P.N. #2 prepared six (6) medications for Resident #26. The medications were ASA (aspirin), Olanzapine, Lisinopril, Cymbalta, Lasix, Lopressor, and Potassium Chloride. L.P.N. #2 was observed to place the potassium tablet in a glass of water. She stated the potassium would dissolve. L.P.N. #2 then placed the ASA, Lisinopril, Olanzapine, Lasix and Lopressor in a medication cup. She removed Cymbalta 30 mg (milligrams) from the package, opened the capsule and placed the contents of the capsule (beads) in the medication cup. L.P.N. #2 then placed all the medications in a plastic sleeve and crushed them. L.P.N. #2 placed the crushed medications in applesauce and administered them to Resident #26 along with the dissolved potassium.

The surveyor asked if the facility had a Do Not Crush list. L.P.N. #2 provided a Do Not Crush list to the surveyor. The surveyor and L.P.N. #2 reviewed the list. Cymbalta (Duloxetine) was listed on the list of medications that are not to be crushed. L.P.N. #2 asked "Is it ok to open the capsule and just give the beads?"

The surveyor reconciled Resident #26's

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	495409	A. BUILDING _____ B. WING _____	C 07/28/2016

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ABINGDON HEALTH CARE LLC	15051 HARMONY HILLS LANE ABINGDON, VA 24212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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medications administered with the signed physician orders dated 7/11/16. Resident #26 did have physician orders that read "Duloxetine HCL Capsule Delayed Release Particles 30 mg Give 1 capsule by mouth one time a day related to ANXIETY STATE, UNSPECIFIED (300.00)."

The surveyor requested the facility contracting pharmacy phone number and placed a call to the contracting pharmacist on 7/27/16 at 9:12 a.m. The surveyor interviewed the contracting pharmacist (other #1) concerning the crushing of Cymbalta. The pharmacist stated he would do his research and inform the surveyor of the results.

The information provided from the contracting pharmacist was reviewed 7/27/16. The information titled "Duloxetine HCL (hydrochloride) Alternative Methods of Transmission" read in part "Duloxetine delayed-release capsules should be swallowed whole and should not be chewed or crushed, nor should the capsule be opened and its contents sprinkled on food or mixed with liquids. Based on the findings from that study, the authors concluded that the enteric coating of the duloxetine pellets was not negatively affected after being mixed with applesauce and apple juice (each with a pH of approximately 3.5) provided that the pellets were not crushed, chewed, or otherwise broken (Wells, 2008)."

A return call to the contracting pharmacist on 7/27/16 at 3:09 p.m. was made. The contracting pharmacist stated Cymbalta should not be crushed because it alters the contents of the drug when crushed.

The surveyor informed the administrative staff of

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F 332	Continued From page 38 the above issue on 7/27/16 at 3:50 p.m. No further information was provided prior to the exit conference on 7/28/16. Resident #26 was admitted to the facility 7/10/15 with diagnoses that included but not limited to dementia without behavioral disturbances, heart failure, chronic kidney disease, and brief psychotic disorder. Annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/18/16 assessed Resident #26 with a brief interview for mental status as 08 out of 15.	F 332		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and a facility document review, the facility's staff failed to store, and serve food in a safe and sanitary manner. The findings include: The tray line temperature observation was	F 371	F 371 1. Hot food items which were below 135 degrees were removed from the steam table and returned to the kitchen to be reheated. Noted the server allowed the plastic part of thermometer to touch food items. 2. All residents have the potential to be affected when food items are not held at the proper temperature. 3. The consulting RD will inservice dietary staff regarding holding temperatures at 135 degrees or higher & appropriate use of thermometers. The CDM will in-service dietary staff will be in-	

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conducted on 3 units on 7/26/16 starting at 5:00pm. The surveyor asked the server to check the tray line temperatures on the 1st unit. The temperatures on the tray line were not maintained at 135 degrees or greater. On the 1st unit the puree meat was 130 degrees the pureed vegetables was 134 degrees. When the French fries were 126 degrees the surveyor asked the server what she was going to do, she did not respond for a while and then said " I will need to take it back to the kitchen to be reheated. " She then began to take the food from the steam table. The server also allowed the plastic part of the food thermometer to touch the French fries twice while taking the temperature.

On the 2nd unit the surveyor asked the server to take the tray line temperatures. While taking the temperature of the hamburgers she touched the patties with the plastic part of the thermometer. The surveyor also noticed the hamburger buns still in the plastic bag lying partly on top of the French fries.
The temperature of the French fries was 122 degrees, the puree vegetables were 128.3 degrees, the puree meat was 125.8 and the cooked apple sauce was 131. When the surveyor asked the server what she was going to do about the food she said "I would reheat it, but I have not been educated on what to do."

On the third unit the server also allowed the plastic part of the thermometer to touch the mashed potatoes. The puree vegetables were 123 degrees, the gravy 128 degrees, the mechanical meat 125.8 degrees, the green beans 116 degrees and the applesauce 109 degrees. When asked what she should do about the low temperatures the server said "I would serve it."

serviced regarding proper food temperatures, food preparation, and serving methods to prevent cross contamination.

4. The cooking temperatures & holding temperatures will be checked by the cook prior to food items being transported to the serving units and recorded on daily logs for all 3 meals. This will be an ongoing process. The CDM or Supervisor will check temperatures 5 meals per week x 4 weeks, 3 meals per week x 4 weeks, followed by 2 meals per week x 4 weeks. CDM / Supervisor / RD will conduct sanitation rounds 2 times per week for 4 weeks and then weekly X 8. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.
5. Correction date September 12, 2016.

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F 371	Continued From page 40 A meeting was held with the dietary manager and the dietician on the morning of 7/27/16 at 10:00 am. During the meeting the tray line temperatures and the aforementioned concerns was discussed. At the end of the day meeting on 7/27/16 the kitchen issues were discussed with the administrative staff. Prior to exit on 7/28/16 the dietician informed the surveyor of in-service education with the dietary staff related to the aforementioned concerns.	F 371	Refer to Page 39	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 27 residents (Resident #8) was seen by the physician at least every 60 days with a grace period of 10 days. Resident #8 was not seen by the physician for 90 days. The findings included: Resident #8 was not seen by the physician for 90 days. The clinical record of Resident #8 was reviewed	F 387	**F 387 Frequency and Timeliness of Physicians Visits** 1. Resident # 8 has been seen by MD. 2. Any resident has the potential to be affected if timely physician visits are not obtained. Medical Records will complete an audit of physician visit dates to determine if any other residents are affected. 3. The D.O.N. will educate Medical Records Secretary on scheduling physician visits at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.	

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F 387	Continued From page 41 7/26/16 and 7/27/16. Resident #8 was admitted to Ihe facility 10/25/13 with diagnoses that included but not limited to hemiplegia and hemiparesis following cerebrovascular disease affecting unspecified side, pseudobulbar effect, vascular dementia without behavioral disturbance, chronic obstructive pulmonary disease, Type 2 diabetes mellitus, dysphagia, insomnia, major depressive disorder, hypertension, blepharitis left lower eyelid, nuclear cataract, bilateral, migraine without aura, Vitamin B12 deficiency, Vitamin D deficiency, and anxiety. Resident #8's significant change in MDS (minimum data set) assessment with an assessment reference date (ARD) of 6/6/16 assessed the resident with a BIMS (brief interview for mental status) as 9 out of 15. The surveyor reviewed the physician visits from August 2015 through present. Resident #8 was seen by the physician and a note written on 12/16/15 and then on 3/15/16. The surveyor was unable to locate a physician visit between these two dates. The time between physician visits was 90 days. The surveyor informed the administrative staff of the above finding on 7/27/16 at 3:50 p.m. The surveyor was informed by the administrator on 7/28/16 at 8:00 a.m. that a physician visit note could not be found. No further information was provided prior to the exit conference on 7/28/16.	F 387	4. The D.O.N. and Medical Records Secretary will review physician visit schedules weekly for accuracy for 3 months. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. Correction date September 12, 2016	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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F 425	Continued From page 42 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure medications were available for 2 of 27 residents. (Resident #12 and #13) The findings included: 1. The facility staff failed to ensure that Prilosec was available for administration to Resident #12. Resident #12 was readmitted to the facility on 3/16/16 with the following diagnoses of, but not limited to irregular heartbeat, high blood pressure,	F 425	**F 425 Pharmaceutical Svc. Accurate Procedures** 1. The attending physician for resident #12 was informed of the missing documentation for administration of Prilosec packet on 7/24, 7/25 and 7/26/16. There was no negative outcome to resident #10. The attending physician for resident #13 was informed of the missing documentation for administration of Prilosec on 7/10/16. There was no negative outcome to resident #13. MARs were reviewed, pharmacy called and medications received for residents # 12 and #13. 2. Any resident has the potential to be affected if medication is not available as ordered. 3. Licensed nursing staff will be educated on medication administration to include the facility's policy and procedure for obtaining medication from the pharmacy in a timely manner and use of emergency stat box	

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end-stage kidney disease, diabetes, depression, dysphagia, sleep apnea and gastrostomy. The resident was coded on the MDS with an ARD (Assessment Protocol Date) of 6/23/16 had a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #12 was also coded as requiring extensive assistance with 1 staff member for dressing and personal hygiene.

The surveyor conducted a review Resident #12 ' s clinical record on 7/27/16. The surveyor noted an order " Prilosec Packet 10 mg (milligram) ...Give 1 packet via (by) peg tube in the morning ... " It was noted on the Resident ' s MAR (Medication Administration Record) on 7/24/16 at 6 am, 7/25/16 at 6 am and 7/26/16 at 6 am that Prilosec was not given. In the nurses ' notes for the above documented dates and times, the surveyor noted documentation that stated " not here from pharmacy " or " not in from pharmacy. "

Unit Manager #1 was notified of the above documented findings on 7/27/16 at 5:45 pm by the surveyor.

On 7/28/16 at 1 pm, Unit Manager #1 stated, " The staff had run out of the Prilosec packets and were waiting to get it from pharmacy.

The administrator, director of nursing, assistant director of nursing and the clinical services specialist were notified of the above documented findings on 7/28/16 at 3:15 pm.

No further information was provided to the surveyor prior to the exit conference on 7/28/16.

4. The Director of Nursing and/or designee will audit the 24 hour clinical report to ensure medication availability daily (M-F) x4 weeks, then weekly x8 weeks. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.
5. Correction date September 12, 2016

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2. The facility staff failed to ensure that Prilosec was available for administration to Resident #13.

Resident #13 was readmitted to the facility on 3/30/16 with the following diagnoses of, but not limited to blood clot, thyroid disorder, dementia, Parkinson ' s Disease, seizures, respiratory failure, intracranial hemorrhage, tracheostomy, gastrostomy and chronic pain. The resident was coded, on the MDS (an assessment protocol) with an ARD (Assessment Reference Date) of 7/15/16 as having short and long term memory loss. Resident #13 was also coded as being severely impaired to make daily decisions. The resident requires extensive assistance with 2 or more staff members for dressing and personal hygiene and was totally dependent on staff for bathing.

The clinical record of Resident #13 was reviewed by the surveyor on 7/27/2016. In the nurses ' notes for 7/10/16 at 2:26 pm and at 10:03 pm, the surveyor noted there was documentation that stated, " awaiting from pharmacy. " There was no documentation of the medication that staff was waiting from pharmacy to obtain.

Unit Manager #1 was notified of the above documented findings on 7/27/16 at 5:45 pm by the surveyor.

On 7/28/16 at 1 pm, the surveyor asked Unit Manager #1 if she knew what medication was being referred to in the nurses ' notes on the above days for Resident #13. Unit Manager #1 stated, " It was the Prilosec that the staff was waiting to get from pharmacy. "

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F 425	Continued From page 45 The administrator, director of nursing, assistant director of nursing and the clinical services specialist were notified of the above documented findings on 7/28/16 at 3:15 pm. No further information was provided to the surveyor prior to the exit conference on 7/28/16.	F 425	Please refer to page 43	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	**F 441 Infection Control** 1. Handwashing education was completed with nurse #3 in regards to Resident # 25 and # 27. Education was completed with nurse # 4 on infection control and handwashing when performing wound care in regards to Resident # 4. 2. Any resident has the potential to be affected if handwashing is not performed. 3. The DON will educate licensed nursing staff on the importance of handwashing and infection control when administering medication or performing wound care.	

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F 441	Continued From page 46 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control guidelines for 3 of 27 residents (Resident #25, Resident #27, and Resident #4). The findings included: 1. The facility staff failed to perform hand hygiene during a medication pass observation that affected Resident #25 and Resident #27. The surveyor observed a medication pass and pour with licensed practical nurse #3 on 7/26/16 at 4:15 p.m. L.P.N. #3 obtained a blood sugar from Resident #25 and then prepared Resident #25 ' s evening insulin injection. L.P.N. #3 donned non-sterile gloves and administered the insulin in the left abdomen, discarded both sharps and removed the gloves. L.P.N. #3 did not perform hand hygiene. L.P.N. #3 then began to set up Resident #27's medications that included three medications and was observed administering them. L.P.N. #3 did not perform hand hygiene between the two residents observed in the medication pass. The surveyor requested the facility policy on	F 441	4. DON and/or designee will conduct (3) medication pass observations weekly X 4 weeks and then (1) weekly X 8 weeks to monitor for appropriate handwashing. DON or designee will conduct (2) wound care observation weekly X 4 weeks and then (1) wound care observation weekly X 8 weeks to monitor for appropriate handwashing. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 5. Correction date September 12, 2016	

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Handwashing/Hand Hygiene from registered nurse #4 on 7/27/16 at 8:00 a.m.

The facility policy titled "Procedure for Handwashing" included a section that read "When to Wash Hands (at a minimum)." The section read in part "Before and after resident contact."

The facility management team was made aware of the findings on 7/27/16 at 3:50 p.m.
The administrative nurses in the meeting were asked when hands should be washed. The corporate nurse #2 stated between residents.
Resident #25 was admitted to the facility 5/20/16 with diagnoses that included pneumonia, chronic respiratory failure, chronic obstructive pulmonary disease, dysphagia, and Type 2 diabetes mellitus.
Section C of the significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/26/16 was not provided to the surveyor as requested.
Resident #27 was admitted to the facility 11/21/13 with diagnoses that included but not limited to chronic inflammatory demyelinating polyneuritis, Type 2 diabetes mellitus, dementia without behavioral disturbances, hypertension, and dry eye syndrome. Annual MDS assessment with an ARD date of 7/15/16 assessed the resident with a cognitive summary score of 14.
No further information was provided prior to the exit conference on 7/28/16.
2. The facility staff failed to follow infection control guidelines during a wound care observation on Resident #4. L.P.N. #4 failed to change gloves and wash hands when moving from a contaminated area to a clean area.
The clinical record of Resident #4 was reviewed

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7/26/16 and 7/27/16. Resident #4 was admitted to the facility 10/3/13 with diagnoses that included but not limited to Alzheimer ' s disease, anxiety, dysphagia, gastroesophageal reflux disease, glaucoma, atherosclerotic heart disease, gastrostomy, peripheral vascular disease, and hereditary and idiopathic neuropathy.

Resident #4's significant change in assessment with an assessment reference date (ARD) of 6/30/16 assessed the resident with a cognitive summary score of 10 out of 15 in Section C Summary Score. Further review of the significant change MDS revealed in Section G Functional Status and more specifically G0120 Bathing that there were "dash marks" for A. Self-Performance and B. Support Provided. Section K had a dash mark for height.

The surveyor observed Resident #4's wound care performed by L.P.N. #4 on 7/26/16 at 1:10 p.m. L.P.N. #4 placed a barrier on ½ of the over the bed table. The other part of the over the bed table contained an ice cooler with Resident #4 ' s thickened liquids. L.P.N. #4 washed hands, donned gloves and removed the old dressing. Washed hands and applied gloves and cleaned the area on Resident #4 ' s right ankle and discarded the soiled gauze. L.P.N. #4 then applied a foam dressing pre-dated with the current date of 7/26/16. L.P.N. #4 failed to remove gloves and apply clean gloves after cleaning the wound.
The surveyor requested the facility policy on dressing changes from registered nurse #4 on 7/27/16 at 8:00 a.m.
The surveyor reviewed the facility policy titled "Dressings-Clean Technique" on 7/27/16. The policy read in part "4. Wash your hands and

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ABINGDON HEALTH CARE LLC	15051 HARMONY HILLS LANE ABINGDON, VA 24212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 49 apply non-sterile gloves. 5. Remove soiled dressing, place in disposal bag. 6. Wash your hands. 7. Open packages. Place in easily reached area on a clean towel. 8. Antiseptic, if used. 9. Open and apply non-sterile gloves. 10. Using a 4 x4, clean area using one stroke from inner to outer aspect of wound or incision and discard 4 x 4. Use antiseptic, if ordered. 11. Remove gloves. 12. Wash hands. 13. Apply non-sterile gloves. 14. Reapply dry non-sterile dressing." The surveyor interviewed L.P.N. #4 on 7/27/16 at 1:30 p.m. The surveyor questioned if gloves should be changed and hands should be washed after cleaning a wound and before applying a clean dressing. L.P.N. #4 stated she usually changed gloves and washed hands after cleaning wounds. The surveyor informed the administrative staff of the above concern during an end of the day meeting on 7/27/16 at 3:50 p.m. No further information was provided prior to the exit conference on 7/28/16.	F 441	Please refer to page 46	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician ordered laboratory tests for 1 of 27 residents (Resident #3). The staff failed to obtain a hemoccult stool ordered on 6/7/16.	F 502	**F 502 Administration/Labs** 1. It is duly noted that Resident # 3 did not have hemocult stool sample taken as ordered on 6/7/16. 2. Any resident has the potential to be affected if labs are not obtained as ordered. 3. Licensed staff have been educated on the importance of obtaining all labs that have been ordered for any resident as well as the process for documenting physicians orders for labs.	

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F 502	Continued From page 50	F 502		

The findings included:

The staff failed to obtain a hemoccult stool ordered on 6/7/16 for Resident #3.
The clinical record of Resident #3 was reviewed 7/26/16 and 7/27/16. Resident #3 was admitted to the facility on 12/7/12 and readmitted on 7/14/16 with diagnoses that included but not limited to unspecified intellectual disabilities, pneumonitis, status epilepticus, dysphagia, bipolar disorder, osteoporosis (age related), hypokalemia, sleep apnea, restless legs syndrome, anxiety, osteoarthritis, and gastroesophageal reflux disease.
Resident #3's annual MDS with an assessment reference date (ARD) of 11/17/15 coded the resident with a cognitive summary score of 13 out of 15 in Section C0500. Resident #3 needed supervision of one person for toileting.

A telephone order dated 6/7/16 read to check (v) hemacult (sic) stool x1. Check iron, ferritin, B12 & folate.

The surveyor located the results of the iron, ferritin, B12 and folate levels but was able to locate the results of the hemoccult stool.

The surveyor informed registered nurse #1 of the inability to locate the results of the physician order on 7/27/16 at 1:30 p.m.

The surveyor reviewed the progress notes for 6/7/16 and 6/8/16. There was no documentation that the stool had been obtained. The physician note dated 6/7/16 read to check the stool and obtain the blood work ordered above. Follow-up with labs.

4. The Unit Manager and/or designee will audit lab orders and results daily (M-F) x4 weeks, then weekly x8 weeks in the clinical meeting. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.
5. Correction date September 12, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495409	A. BUILDING _____ B. WING _____	C 07/28/2016

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F 502	Continued From page 51 The surveyor was provided the bowel continence record for June 2016. R.N. #1 stated Resident #3 was independent in toileting. R.N. #1 stated the laboratory was called and there was no record the stool specimen/physician order was obtained. The surveyor informed the administrative staff of the above finding on 7/27/16 at 3:50 p.m. No further information was provided prior to the exit conference on 7/28/16.	F 502	Please refer to page 50	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 3 of 27 residents. (Resident #12, #17 and #19) The findings included:	F 514	**F 514 Records-Complete/ accurate** 1. Residents # 12 and #17 incomplete documentation of baths is noted. Bath schedules for both residents have been reviewed. The incomplete documentation of recording Resident #19s blood glucose recheck in the medical record in an hour if blood glucose was > 500 was reviewed with LPN #5 2. Any resident's medical record has the potential to be affected if there is incomplete bathing documentation or incomplete blood glucose documentation. Facility will audit to determine what residents have follow-up blood glucose orders for specific parameters to who else is potentially at risk.	

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 52	F 514		

1. The facility staff failed to document baths in the clinical record for Resident #12.

Resident #12 was readmitted to the facility on 3/16/16 with the following diagnoses of, but not limited to irregular heartbeat, high blood pressure, end-stage kidney disease, diabetes, depression, dysphagia, sleep apnea and gastrostomy. The resident was coded on the MDS with an ARD (Assessment Protocol Date) of 6/23/16 had a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #12 was also coded as requiring extensive assistance with 1 staff member for dressing and personal hygiene.

The surveyor conducted a review Resident #12 ' s clinical record on 7/27/16. It was noted that baths were not documented on 5/2/16, 5/9/16 and 5/19/16.

Unit Manager #1 was notified of the above documented findings on 7/27/16 at 5:45 pm by the surveyor.

On 7/28/16 at 1 pm, Unit Manager stated " We have looked at the Resident ' s chart and we cannot find out why the baths were not documented. "

The administrator, director of nursing, assistant director of nursing and clinical services specialist were notified of the above documented findings on 7/28/16 at 3:15 pm.

No further documentation was provided to the surveyor prior to the exit conference on 7/28/16.

3. Licensed staff will be educated regarding the use of Point Click Care (PCC) and documentation of baths given for each resident.
Licensed nursing staff will also be educated on the importance of getting pertinent medical documentation such as blood glucose rechecks into the medical record to ensure it is complete and accurate.
4. The DON and/or designee will audit bathing schedules and blood sugar documentation where there are follow-up orders for specific parameters daily (M-F) x4 weeks, then weekly x8 weeks in the clinical meeting. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.
5. Correction date September 12, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 53 2. The facility staff failed to document baths in the clinical record for Resident #17. Resident #17 was admitted to the facility on 4/20/16 with the following diagnoses of, but not limited to end stage renal disease, dialysis, diabetes, thyroid disorder and bacterial pneumonia. The resident was coded, on the MDS (an assessment protocol) with an ARD (Assessment Reference Date) of 4/27/16 as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #17 required limited assistance of 1 staff member for dressing and personal hygiene. The clinical record of Resident #17 was reviewed by the surveyor on 7/28/2016. It was noted that on 7/23/16, 6/1/16, 6/4/16, 6/15/16 and 6/25/16 that baths were not documented for Resident #17. Unit Manager #1 was notified of the above documented findings by the surveyor on 7/28/16 at 1 pm. On 7/28/16 at 2:30 pm, Unit Manager #1 stated, " It ' s like the other one. We cannot find out why the baths were not documented. " The administrator, director of nursing, assistant director of nursing and the clinical services specialist were notified of the above documented findings on 7/28/16 at 3:15 pm. No further information was provided to the surveyor prior to the exit conference on 7/28/16. 3. For Resident #19, the facility staff failed to maintain a complete and accurate clinical record in regards to the Residents BS (blood sugars).	F 514	Please refer to page 52	

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F 514	Continued From page 54	F 514		

The facility nursing staff failed to document the Residents BS in the clinical record.

Resident #19 was admitted to the facility 08/28/15. Diagnoses included, but were not limited to, dementia, chronic kidney disease, diabetes, anemia, restless leg syndrome, depressive disorder, and diabetic neuropathy.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/29/16 had a summary score of 15 out of a possible 15 points. Indicating the Resident was alert and orientated. Section I (active diagnoses) included the diagnosis of diabetes.

The Residents clinical record included the following physician orders:
BS (blood sugar) q (every) AC (before meals) & HS (bedtime/hour of sleep) for DMII (diabetes mellitus type 2).
Humalog insulin inject as per sliding scale...501-600=25 units Recheck BS in 1 hour. If still greater than 500 notify MD (medical doctor).

A review of the Residents eMAR (electronic medication administration records) indicated that the staff had documented that the Residents BS was 555 on 07/21/16 at 2100 (9:00 p.m.) and was 525 on 07/24/16 at 11:30 a.m. The surveyor was unable to locate any information to indicate the BS had been retaken within 1 hour.

On 07/28/16 at approximately 11:00 a.m. the surveyor and LPN (licensed practical nurse) #5 reviewed the Residents eMAR LPN #5 identified her initials for 07/24/16. When asked if she had

Please refer to page 52

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F 514	Continued From page 55	F 514		

retaken the Residents BS she stated she had and stated she wrote it down in a notebook. LPN #5 reached to the side of her medication cart and opened a notebook. Inside she had documented the Residents BS as being 216. LPN #5 stated she always wrote everything down in this notebook so she could reference it if needed. This was LPN #5's personal notebook and not part of the clinical record.

The administrative staff were notified of the inaccurate clinical record in regards to the Residents blood sugars in a meeting with the survey team on 07/28/16 at approximately 3:15 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 000	Initial Comments	F 000		

An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 07/26/16 through 07/28/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 120 certified bed facility was 115 at the time of the survey. The survey sample consisted of 27total residents with 23 current Resident reviews (Residents #1 through #20 and #25, #26, #27) and 4 closed record reviews (Residents #21 through #24).

F 001 Non Compliance — F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
A biennial State Licensure Inspection was conducted 07/26/16 through 07/28/16. The facility was not in compliance with the following Virginia Nursing Home Rules and Regulations:

12 VAC 5-371-360 A &E cross-reference to F514 — Cross-reference to F 514 page 52

12 VAC 5-371-310B cross-reference to F502 — Cross-reference to 502 page 50
12 VAC 5-371- 220A cross-reference to F309 — Cross-reference to F 309 page 23

12 VAC 5-371-250 (A.1 THRU A.14) Cross Reference to F-272 — Cross – reference F 272 page 1
12 VAC 5-371-250 (F, H, I) Cross Reference to F-280 — Cross-reference F 280 page 20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephen J Reynolds — TITLE: Administrator — (X6) DATE: 8/15/16

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F 001	Continued From Page 1	F 001		

12 VAC 5-371-300 (A,C,G) Cross reference to F-425.

Cross reference to F 425 on page 43

12 VAC 5-371-250 (G) Cross Reference to F-279

Cross reference to F 279 on page 18

12 VAC 5-371-220 (B) Cross reference to F-332.
12 VAC 5-371-340 (A) Cross reference to F-371.

Cross reference to F 332 on page 34

12 VAC 5-371-300 (J.3) Cross reference to F-431.

Cross reference to F 371 on page 39

12 VAC 5-371-180 (A,B,C) Cross reference to F-441

Cross reference to F 441 on page 46